Special Learning Center

NEW PATIENT INTAKE

PERSONAL INFORMATION

Child's Legal Name: _____ Date of Birth: _____

Age: _____ Sex: _____ Primary Care/Pediatrician: _____

Legal Guardians: _____

Please check the box that would be preferred contact and list the associated name and number.

Home Ph:_____ ☐ Cell Ph: _____ ☐

Work Ph: _____ ☐ Best number to reach you at: _____

Email: _____

Physical Address: _____ City, State, Zip: _____

Mailing Address: _____ City, State, Zip: _____

Occupation(s): _____ Employer(s): _____

Please list names and phone number of the individuals who may/will drop off at therapy other than primary individuals: _____

INSURANCE INFORMATION (please fill out ALL areas) Please include a front and back copy of insurance card.

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

Insured's Name: _____ Insured's Name: _____

Insured's DOB: _____ Insured's DOB: _____

Please initial the following statement if TRUE:

_____ I DO NOT HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAT THE ABOVE MENTIONED.

We highly recommend that you contact your insurance company before your first appointment to confirm insurance coverage for therapy services. It is important to understand what services are covered and what you are responsible for paying out of pocket.

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IMPORTANT INSURANCE RELATED QUESTIONS

It is your responsibility as a parent/caregiver to know what your insurance benefits/coverage are for your child. Below are several important questions to ask when calling the insurance company regarding coverage of therapy services.

1. My child is ____old. Does our policy cover his/her PT/OT services?

2. What conditions/diagnoses will insurance specifically cover?

3. Do I need to obtain pre-authorization for therapy services?

4. How many visits will insurance cover? Is that total visits or visits per discipline (for example, X visits for physical therapy and X visits of occupational therapy)?

5. Do I have a deductible?

6. Do I have co-pay for each visit?

7. What services are you interested in for your child? _____ PT _____ OT _____ Speech _____ Intensive

FINANCIAL HARDSHIP INFORMATION

SKIP Clinic understands that some therapy services and interventions may have little or no insurance coverage or some families may not have therapy coverage with their insurance package. We understand this may result in significant financial strain for families. SKIP Clinic has a scholarship application to assist with easing some of the financial burden allowing children to continue to receive the therapy they need to help them reach their full potential. If interested in completing an application, please email scholarship@speciallearningcenter.com

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Patient Name:	Date of Birth:

Initial	Item	Item Description
	Consent to Treat	I give consent for my child to receive the necessary evaluation and/or treatment by SKIP Clinic.
	Video Surveillance Acknowledgement	In an aid to enhance the quality of care, SKIP Clinic may use an electronic surveillance system to record visual occurrences on the facility's internal and external grounds, the only exception being private areas of restrooms. I acknowledge that I am aware SKIP Clinic may use an electronic surveillance system and I understand that video surveillance may be used for training, safety and investigative purposes.
	Email Consent for Appointments and Billing and Enrollment in Patient Portal	I acknowledge that SKIP Clinic can contact me through email for appointment, financial, and treatment updates. I understand the risks that are associated with using this form of communication, including but not limited to information regarding your child's treatment may be accessible to other parties on the web. SKIP Clinic will use reasonable means to protect the information sent and received by email and will treat such email messages with the same degree of confidentiality as medical records. I understand that SKIP Clinic cannot guarantee the security and confidentiality of email communications and I still request to use this form of communication knowing the risks. I may withdraw this consent at any time by written communications with the office manager. Preferred email address for correspondence: _____ ☐ I would like to receive my billing and financial statements through email.
	Text Consent	I authorize SKIP Clinic to send text messages to my cell phone related to my child's therapy. I understand that communication via text message is not secure and may potentially be intercepted by a third party. I understand that standard data and text messaging rates will apply to any messages received from SKIP Clinic. I agree not to hold SKIP Clinic liable for any electronic messaging charges or fees generated by this service. I understand that SKIP Clinic text messages to my cell phone are not secure and potentially could be intercepted by an outside party.

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Initial	**Item**	**Item Description**
	Emergency Medical Release	In the event medical attention is required for my child while on the premises of SKIP Clinic I authoritative them to implement treatment. Hospital Preference: _____
	Photo Permission	I give permission for photos/videos of my child to be used for the purposes of treatment, education, and documentation. ☐ I give permission for photos/video of my child to be used for advertising, brochure, and/or webspace.
	Acknowledgement of receipt of notice of privacy practices (HIPPA)	I acknowledged that I have viewed, read, and understand the HIPAA Policy (attached at the end of this packet) and have been informed of my rights as a patient's parent/guardian.
	Financial Policy	I understand that my child's medical insurance is a contract between myself and my insurance company; I will provide the SKIP Clinic with my child's complete health insurance information before his/her appointment. SKIP Clinic will work to verify my insurance coverage before my child's arrival and to obtain authorization or certification from my insurance plan as needed. I understand and agree that I am financially responsible for all co-pays, coinsurance and amounts not covered by my healthcare provider. This charge is expected at time of services. As a courtesy, SKIP Clinic patient service specialists will review my plans' benefits received from my insurance company and work with me on payment options, if needed.
	Assignment of Benefits	I certify that the information given by me in applying for payment is correct. I hereby authorize payment by my insurance carrier of the benefits, otherwise payable to me, to be made directly to SKIP Clinic for their services. I authorize SKIP Clinic to release all insurance companies and/or compensation carriers only such as diagnostic, therapeutic, and financial information as may be necessary to determine benefits entitled and to process payment claims for health services that will be provided.

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Information Regarding Billing and Financial Responsibility

SKIP Clinic will require every family with patient responsibility (private pay and co-pay amounts) to have a credit card on file. Co-payments will be collected at time of service. Any additional cost towards your deductible or co-insurance will be billed to you after processing through your insurance plan. SKIP Clinic bills insurance companies on date of service, but please know it may take several months after dates of services for insurance to provide us with the final bill. SKIP Clinic requires that all outstanding patient balances above $300 must be reconciled or have a payment plan in place to continue services. Please see the Administrative Assistant to store a card securely on file for your child. You may also verbally provide this to the office when you check in for your evaluation. You may change your method of payment at any time.

I understand that patient responsibility for services provided by SKIP Clinic are due at the time services are rendered. I give SKIP Clinic permission to charge my credit card on file for copays/deductible plan pre-pay or any other financial payment plan arrangements made with The SKIP Clinic for services provided to my child.

_____ _____

Signed Date

I understand the practices and policies of SKIP Clinic that I have initialed above.

Parent/Guardian Signature:	Date:

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INTER-AGENCY AUTHORIZATION FOR EXCHANGE OF INFORMATION

I understand this information will be used to plan/coordinate care for my child and is confidential between or among these agencies/providers.

Please list the names of the people/programs that work with your child.

Service	Hospital/Clinic	Provider Name	Date Last Seen
Pediatrician/Physician			
Specialists			
Preschool/School			
Childcare			
Physical Therapist			
Speech Therapist			
Occupational Therapist			
Counselor/Psychologist			
Equipment Supplier			
Division of Family Services			
Caseworker/Case Coordinator			
Dietician/Nutritionist			
Hospital			
Orthotist			
Assistive Technology Professional			
Other			

Specific Information requested:_____

****If your child has an IEP, IFSP, or additional testing/reports, please bring us a copy for our records.****

I hereby authorize any prior or present treating physician, therapist, school, hospital or other health institution, to release all medical information by any means of communication between the entities listed above and Special Learning Center.

_____ _____

Parent/Legal Guardian Signature **Date**

_____ *Initial Here*

I authorize the release of information pertaining to my child necessary for programming, coordination of care, and best practices to be shared among the organizations of Special Learning Center including SKIP Clinic, Family Support and Outreach, Childcare and Early Childhood Special Education.

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Our center is dedicated to maintaining the privacy of your child's individually identifiable health information (IIHI). Your child's records (as required by law) are maintained in strictest confidentiality. We are required by law to provide you with this notice regarding IIHI. This notice applies to personal medical/health information that we have about your child and which is kept at this agency. If you have any questions, please contact the Privacy Officer for this facility.

Without your permission, we may use your child's personal information:

- As required by State, Federal, or local law. This includes investigations, audits, inspections and licensure
- When ordered to do so by a court
- Public health risks
- To send you appointment reminders regarding your child.

Your rights regarding your child's IIHI:

- Confidential Communications with you regarding your child
- Inspection and copies of your child's records that are generated by our agency
- Right to file a complaint
- Right to provide an authorization for other uses and disclosures
- To file a complaint if you believe any of your child's rights have been violated.

If you wish to exercise any of these rights or file a complaint, you should contact the Privacy Officer of this facility:

SKIP Clinic
2209 Stone Hill Road Jefferson City, MO 65101
Phone: (573) 634-3070 x1518